DR. CHARLES DAVIS
ARMED FORCES INSTITUTE OF PATHOLOGY
ORAL HISTORY PROGRAM

INTERVIEWER: Charles Stuart Kennedy
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Q: Dr. Davis, welcome to our program. I would like to ask you if you could give me something about your background, when you were born, where were you born, and a little about some of your family, what your parents were doing and all.

DR. DAVIS: Well, I was born in South Charleston, West Virginia. I lived around that part of the country, around Charleston and Nitro, until I started to college. Went to West Virginia University and took premed.

Q: When you were a young lad, were there any members of the family or any friends of the family in the medical field that attracted you to medicine?

DR. DAVIS: No, no, there really wasn't. My father was an electrician, and my mother didn't work. I liked to read.

I spent two years in the Army as an enlisted man, just toward the tail end of the war.

Q: You're talking about World War II.

DR. DAVIS: Yes, World War II. When I came home after that, I was 19 years old. Actually, because of the GI Bill, all of my old friends were going to college, and so I said, well, obviously, that's the thing for me to do, to go to college. So I went to college. Now I'm from a small town; I'll show you how knowledgeable I was. I went up to the lady, and she said, "What do you want to major in?"

I said, "What do you mean?"

She said, "Well, what do you want to do when you get out of here?"

I said, "Well, what are the choices?"

And she went down a list: law, selling, business. I sort of mentally crossed them off as she went along. And when she got to medicine, I said, "That sounds pretty good."

I probably had done some thinking about it, but I don't really remember very clearly.

So I went to medical school.

Q: You went where, to the University of West Virginia?

DR. DAVIS: Well, back in those days, in the late '40s and early '50s, West Virginia University, in Morgantown, had a two-year school. At the end of that time, they had some deal with the State of Virginia that we'd all go over to Richmond. So I had the second two years at the

Medical College of Virginia.

And then I went back to Charleston for an internship and a year of residency in internal medicine, whereupon I went into general practice for about five or six years.

Q: When you were going through medical school, both in Virginia and West Virginia, did you get involved at all in pathology?

DR. DAVIS: No, no, I really didn't. I didn't know what I wanted to do. This was at a time when most doctors were still general practitioners, and the age of specialization was just coming on. In fact, in medical school, they were still making a big pitch for us all to stay in general practice. That was in '53, and during the early '50s and mid-50s, the general practitioners began to diminish, and most people were specializing. And when I was doing general practice and making house calls in rural West Virginia, it became increasingly apparent to me that no matter what I was treating, there was always somebody downtown who knew more about it than I did, whether it was pediatricians or internists or surgeons. And this is what began to bother me, so I...

Q: Where were you doing your general practice?

DR. DAVIS: Well, it was in the coal-mining areas of West Virginia. Practically everybody that was eligible for medical care was through the United Mine Workers. The mines were beginning to become automated in the mid-50s, and increasing numbers of the people were getting laid off. All in all, it was becoming somewhat depressing in the area.

So I decided to specialize. I had always liked the objectivity of pathology. So much is subjective about practice; it's just what the word says: it's practice. And back in those days, about the only way one could afford to support a family and also specialize was in the military, because residents at hospitals made very little money. I guess that's why a lot of them stayed single. So I joined the Army and went to William Beaumont, in El Paso, and took a residency in pathology.

Q: Had you more or less sold yourself on pathology as a field, or did you know pathologists?

DR. DAVIS: No, I had some knowledge of it, from dealing with the laboratory as a clinician, but most of what I knew about pathology was strictly from medical school.

Q: So you joined the Army in '53, was it?

DR. DAVIS: No, when I finally came back into the Army, it was in '62. In '62, I gave up general practice and joined the Army. This was back when they had the doctor draft, and here's a doctor who wants to join the Army. It sort of confused everybody. So I had a little bit of red tape, joining the Army.

Q: When you went down to William Beaumont, were you able to pick the specialty you wanted to get into?

DR. DAVIS: Oh, yeah. Yeah.

Q: And was that William Beaumont sort of the Army's pathology place?

DR. DAVIS: No, actually, there were, I guess, maybe a half-dozen or so teaching hospitals where one could go to take a residency. I didn't pick Beaumont, but that's where they had the opening, so that's where I went. It turned out to be a nice assignment.

Q: Were you taking general pathology?

DR. DAVIS: I was taking anatomic pathology and also clinical pathology. It was two years of each; it was four years.

Q: Did you have any connection with the AFIP at that time?

DR. DAVIS: None at all. I began to become acquainted with the AFIP. I'd never heard of it when I joined the Army. The people who were teaching me pathology, when they had a problem case, they would pack it up and mail it to the AFIP. And that's when I first heard of the place. But, even then, I hadn't thought about ever working here. That came sometime later.

Q: During your four years at Beaumont, were there any types of cases that were particularly noticeable?

DR. DAVIS: No, everything's pretty much the same in El Paso. In the Southwest, they have a lot of coccidial oidiomycosis. I haven't seen much of that since I left El Paso, but otherwise, there's no difference.

Q: Then, from there, you left when?

DR. DAVIS: I left there in '67, and I asked to be assigned to the East Coast, because my wife and I hadn't seen our families for a while. So we asked to go to Ft. Bragg, and I was assigned as a pathologist at Ft. Bragg, Womack Army Hospital. That way, we could go back and visit West Virginia periodically. So I was there for about three years, as chief of the pathology service.

Q: That's the major infantry school, isn't it?

DR. DAVIS: Yeah, but back then, the Green Berets was the big thing down at Ft. Bragg, and the 82nd Airborne, I guess, has always been there, as long as I can remember. And, of course, the Vietnam affair was going on then, so there was a lot of basic training there, too.

Q: At this particular time, these units you were mentioning were very heavily involved in Vietnam. Well, talking about Vietnam, as a pathologist, were new things coming your way as far as Asian diseases and problems coming out of Asia?

DR. DAVIS: Not that it impacted on us on the East Coast. Later on, I became acquainted with some of those things, when I actually went to Vietnam. But the practice of medicine itself wasn't affected on the East Coast by what was going on in Vietnam.

Q: Many of these special forces, for example, as you know, were up in the highlands and places where they certainly could pick up exotic bugs.

DR. DAVIS: That's true, but I just don't recall that we ever became involved with, for example, malaria, on the East Coast, at least not where I was.

Q: Now after Ft. Bragg, where did you go?

DR. DAVIS: Well, then I went to Vietnam.

Q: Where did you serve in Vietnam?

DR. DAVIS: I went over there as the commanding officer of the 9th Medical Laboratory. The Army had constructed this huge military base about half an hour north of Saigon.

Q: At Long-hoa?

DR. DAVIS: Long-binh.

Q: When did you go there?

DR. DAVIS: I went there in June of '70.

Q: I know the Long-binh base. I was at the embassy just at that time when you were there, from '69 to '70. How did you find your work in Vietnam?

DR. DAVIS: Well, it was coming to be rather hectic, because, if you recall, this was back when drugs became a problem. As my one-year tour approached the midpoint, the reaction in the government to drugs in Vietnam was reaching the flash point, and there was a lot of pressure to do something about it. This impacted quite a bit on our laboratory, because if a way was to be found to detect drug use in soldiers, it would be the laboratory, one way or the other, that would be involved. So it was rather hectic. And I was there when they decided to start testing everybody leaving the country.

Q: If I recall, on the radio, I used to hear about Operation Golden Flow.

DR. DAVIS: I hadn't heard that term, but, yeah, that's exactly what it was. And there was a mad scramble to construct screening points around. They had one in Binh-hoa and one in Long-binh

and one at Tan-sanu, down at Saigon. They constructed these screening points for the soldiers to go in and make the "golden stream," and our laboratory would process these urine specimens. But getting that set up and getting all the commanding officers over there to appreciate that they had to do this... Some of the unit commanders were saying it wasn't practical. I said, "I know it's not practical. It's going to have to work, though." Nixon was in the White House then, and he called my commanding officer and said, "We need to know, is the testing going to start in the morning?"

And so my commanding officer called me and said, "Is it going to start in the morning?"

I said, "Well, Col. So and So over at the replacement depot is saying he's not sure he can do this." I told him, "Our laboratory's going to be there."

So the general put the pressure on him, and his men showed up.

Q: What was the lab showing? These were people leaving Vietnam?

DR. DAVIS: Yeah.

Q: On R&R, or...

DR. DAVIS: No, everybody rotating back home. You recall, back in '71, they were beginning to downsize. We were starting to come home. They weren't building up anymore, they were building down. And everybody who rotated back to the States was tested for drug use.

It was about this time that some company in California came up with a sophisticated method of testing for drugs. It was called the frat machine, using basically an antigen antibody reaction to test for morphine and so forth. And since this was a new technique, anything they found positive, we would double check in the laboratory with a proven method, thin-layer chromatography.

Actually, a lot of our people who weren't chemists had to become chemists overnight. And our chemists were working around the clock to do this.

Q: This must have had a tremendous impact on your other work.

DR. DAVIS: That's true. For example, the blood depot up at Cam-ranh Bay was a very well-honed and smoothly operating apparatus, and so these things could pretty well run themselves. We had some good people running the blood bank--Major Jerry Bow, people like that. The bacteriology aspect of the lab had been running over there for some years then, and they had that down to a routine. So, really, about the only place that I was really needed was to honcho the drug-screening program.

Q: What were you finding? How bad was it?

DR. DAVIS: You know, I don't remember. My recollection is that there weren't nearly as many deaths from drugs as the newspapers led us to believe. But I don't recall. Actually, by the time the drug screening really got going and was a smoothly operating thing, it was about the time for

me to go home.

Q: And the troops were really moving out at that time. Well, you came back when, in '71, is that right?

DR. DAVIS: I came back in June of '71.

Q: And then where did you go?

DR. DAVIS: Well, I gathered up my family and brought them to Washington, and I've been here ever since.

Q: Did you go to the AFIP, or did the AFIP go to you? How did you two get together?

DR. DAVIS: Well, Dr. Mostofi was invited to give some lectures at the University of Saigon, so he went over there in December of '70. And after he finished downtown, he came up to visit Long-binh. That's when I first met him, at the 9th Medical Laboratory. He came to visit the laboratory, and when I got through telling him what we were doing, I told him that I was beginning to think about what was I going to do when I got home. I told him that I'd like to go to the AFIP for about a year and learn something about liver biopsies or kidney biopsies, and then, after that, get some special expertise in something, and then go back to the hospital and join one of the residency programs in teaching. Unbeknownst to me, Dr. Price, who had been working for Dr. Mostofi, had already left, and Dr. Mostofi was sorely needing somebody. So that's how I came to the AFIP.

Q: Well, then you started working with Dr. Mostofi, is that correct?

DR. DAVIS: Yes.

Q: What were you working on with him?

DR. DAVIS: Well, his department is the Department of Genitourinary Pathology, pathology of the kidney and the bladder and the prostate and the testes. His department has always been one of the busier departments. There was, as a matter of fact, at the time, considerable backlog, so there was plenty for me to do. By the time we got that in hand, it was becoming apparent that I could do the job, and I felt comfortable with it. And he needed somebody. The family liked Washington better than Fayetteville, so we had become entrenched.

Q: In 1971, how did you find the AFIP, from the point of view of a new doctor looking at it, how it was run and some of the major figures at that time?

DR. DAVIS: Well, I was aware, even before I came, that the Institute had some of the foremost authorities in their specialties. Aside from Dr. Mostofi in the urologic area, there was Dr. Helwig

in the scan and GI (gastrointestinal) area, and there was Dr. Lent Johnson in the bone, and Enzinger in soft tissue, Zimmerman in ophthalmology, and others. I was already aware that these were international authorities on the subject, so I had a very impression of the place.

Q: Again, we're talking about when you first arrived. Was there much interplay between the various departments, or did you pretty well stick with the genitourinary area as far collegial work?

DR. DAVIS: Over the years, there's always been an occasional project in which different departments would cooperate with each other, but for the most part, each one does his own thing. Of course, in everybody's daily work, we very frequently will send diagnostic problems from one department to the other, in consultation.

The main area where there was interdepartmental cooperation used to be something called the annual AFIP lectures, which, back in the '60s and early '70s, was, I would say, the best all-around conference in anatomic pathology. This was a one-week course in which people would come from all over the country and elsewhere and listen to the members of the various departments, one after the other, talk about the projects that they'd been working on. And it made for an outstanding series of lectures. That was the time when one could go to Washington, and within five days, you could hear all the various specialists in pathology and feel like you were up to date on all subjects.

Since the mid-70s, the various medical schools and teaching institutions around the country started their own annual lectures, so to speak. And so there was more competition, and the annual lectures eventually petered out and disappeared.

Q: Where was your work coming from? Was it mainly military? Was it civilian? I'm talking about the cases that were sent for consultation.

DR. DAVIS: I think about half of our work has always been from military hospitals. It waxes and wanes here and there, but I think, over the years, it's stayed right around fifty-fifty with respect to military versus civilian. About half of our cases come from civilian hospitals.

Q: Did you have a particular field within the genitourinary area that you were concentrating on while Dr. Mostofi or somebody else was working on other areas, or was it pretty much everybody working on the same thing?

DR. DAVIS: Well, I suppose most of Dr. Mostofi's interests have been focused on the prostate and testicular tumors. Most of the writing that I have done has been on tumors of the kidney, and tumorlike lesions of the kidney, and cystic diseases of the kidney. That's as far as writing is concerned. As far as the everyday work and consultation cases, most of our work, especially in recent years, has been prostate. There have been some advances in picking up cancer of the prostate. When they came out with a method of doing a biopsy of the prostate in the office, then things really picked up. So I'd say the vast majority of our time nowadays is in looking at biopsies of the prostate. In other words, everybody's chief interest is the prostate.

Q: Since the prostate is mainly for older people, did this mean that it was more a nonmilitary concentration?

DR. DAVIS: No, not necessarily, because of all the retired people, all the veterans. All the VA Hospitals are seeing a lot of prostates.

Q: Have you seen any changes from 1971 to 1993 in the type of problems that you're getting because of changes in American living conditions or types of chemicals, food, or anything else like that?

DR. DAVIS: They've recently started up an environmental program, where we could start studying the possible deleterious effects of things like drugs or environmental exposures. But that hasn't impacted very much at this point. Of course, Dr. Irey's always had a department called The Tissue Reaction to Drugs. But that really is not off the ground yet, environmental medicine.

Q: How about the doctors that are coming in to work for you? With the doctor draft and the Berry Plan, the various things that have come and gone and all, do you notice a change in things?

DR. DAVIS: Oh, yeah. That's probably where there's been the most change, in the type of people coming here to work.

Back in the old days, we did what you'd call clinical research, where you'd gather up all the cases of typhoid or whatever, all of the cases of basal cell carcinoma of the skin, and study them as a group and describe them and write about them. This was clinical pathological correlations. In other words, it's growth pathology and microscopic pathology.

Nowadays, it's more down to the antigen antibody, down to the molecular level, down to the chromosomes. And the people coming here now have an interest in this and an aptitude for this. So it's more sophisticated than it used to be.

Q: Has their been a major change in the types of equipment that you use to deal with your analyses since the early '70s?

DR. DAVIS: Yeah, everything is getting more sophisticated. Microscopes are better, photographic methodology is better, more fancy. Well, everything is more sophisticated than it used to be.

Q: Has your department been able to make any major strides in moving into a field of new research using new types of equipment?

DR. DAVIS: Yes, they have. Not me personally. We have a lady, Dr. Sesterhenn, from Germany, who's been here now for over 15 years, and she's doing some very interesting work with chromosomes; developed a technique where you can actually evaluate chromosomes with a

light microscope, just the same way we used to look at ordinary biopsies with a microscope. She also introduced immunochemistry to our department. We're doing special stains and so forth.

Q: Usually, the AFIP has several missions. One, of course, is doing the consultations, another is training and teaching. Have you been much involved in the teaching side?

DR. DAVIS: Yes, quite a bit. I, periodically, am asked to go out to one of the teaching hospitals and give lectures. For example, in October, I'm going back to Beaumont, in El Paso, to give a series of lectures to their residents and staff. And, periodically, I go to Madigan, up in Washington State. I used to go to Portsmouth Navy Hospital. Almost every year, we give lectures at Walter Reed or at the Navy hospital. Every year, our department puts on a course for urology residents who are getting ready to take their Boards, and they have to know some pathology for their Boards. That's probably the biggest show we put on; we've had, sometimes, over 200 people. I would say most urologists practicing today have been through our course in genitourinary pathology. And, of course, Dr. Mostofi, as you probably know, still travels far and wide, at home and abroad, to give lectures.

Q: You've been here at the Institute since 1971. I'd just like to walk you through about the various directors of the Institute of Pathology and your impression of how they ran things, from your perspective. When you arrived here, Col. Morrissey, from the Air Force, was here. Do you recall him?

DR. DAVIS: Yeah, I remember him very well. I wasn't here when he came to be the director, and he was only here maybe a year or two before he quit.

Q: He left in '73, only two years.

DR. DAVIS: Yeah, he decided to leave before he needed to. He apparently wasn't very happy with the job, for some reason, and he left. I really don't know much about him.

Q: And Col. Hansen.

DR. DAVIS: Col. Hansen was an old-timer in the Army. I thought he was a good director, but I was still relatively new here myself.

Q: And then Elgin Cowart, of the Navy.

DR. DAVIS: I had first met Elgin when I was in Vietnam. He was CO of the hospital ship over there. So we were old friends. I like Elgin; he's a good man.

Q: And William Cowan, of the Air Force, director from '80 to '84.

DR. DAVIS: Ray Cowan. I don't know what you all...

Q: I was just wondering whether he had any effect on the way things were run or not.

DR. DAVIS: No, I think, during this period of time, the directors more or less continued the way things had been going. It wasn't until we get, I think, to Dr. McMeekin that they began to rearrange the organization and restructure the way the Institute was run. I'm sure someone else could describe this much better than I can.

They used to have one of the senior pathologists in charge of the professional staff. When I came here, it was Dr. Helwig. The director ran the administrative affairs. And the executive officer and chairman of the Center for Advanced Pathology was sort of analogous to the chief of staff in a hospital. First, it was Dr. Helwig, and then it was Dr. Mostofi.

Now, they've changed this organization (and I think it started when McMeekin was director), so that they have several different people, associate directors, in charge of different departments.

Q: Is that having much of an effect on the work?

DR. DAVIS: Well, it was supposed to cut down on the amount of paperwork that the chairmen and the departments had, but I don't think it did.

Q: Speaking of paperwork, one of the problems of having these various departments is things come in to you and they have to go out. Has this been a particular problem, of having a timely response?

DR. DAVIS: Yes, over the years, I guess, that has been *the* problem, *the* big problem, to get consultation cases in and out of the building in a timely fashion. It's been a constant struggle.

You'll get an argument on this, but in my view, the cases that come here are not your ordinary cases; someone's had a problem with them. And the type of personality that chooses to stay at the Institute is the type of person who has a little bit of compulsiveness about him. So you take a compulsive person, with a diagnostic problem, and you see what you're faced with.

So turnaround time has always been a problem.

Since they started charging for civilian cases, it has been, at least speaking for myself anyway, an absolute necessity to change your attitude a little bit and get the cases out. I tell myself that I'm not cutting any corners in getting them out quicker. I don't know. All one can do is be aware of the concept of cutting corners. I think we're doing a good job.

Q: What do you see, in these consultation cases, as the great strength of the AFIP?

DR. DAVIS: Well, the great strength of the Institute is... You take a practicing pathologist at a given hospital. There are a lot of things that can come across his desk that he's never seen before. You take, say, a given tumor, for example. All over the country, there's probably somebody finding one of these tumors every day. But at any given hospital, there's an excellent chance that that pathologist has never seen one in his life, and may never see another one. But here at the

Institute, no matter how rare it is, we've some of them. We've seen a number of them.

Q: Do you have, in looking at this whole stretch of time you were there, a good follow-up? Somebody will send you a specimen, you make a finding, and off it goes. Is that the end of it? I would think you would want to know more about what happened later on, how it was treated, what was this or that, to build up your ability to both solve the problem and also to recommend what to do.

DR. DAVIS: Yes, our challenge is to get our consultation work in and out on time, and also have time to do what you just said, go back to the cases you saw last year or last month and see what happened to them. And in this respect, the AFIP is at a little bit of a disadvantage because our patients are not here, they're not downstairs in the bed. The military cases have been rotated to some other base, or rotated out of the service, and they're hard to track. Even the civilian cases are hard to find. So that's been somewhat of a disadvantage; a distinct disadvantage in comparison, say, to some physician in a hospital studying his follow-up cases.

Q: Because he can follow that case pretty much.

DR. DAVIS: The patient probably lives in town.

Q: You alluded to it, but in the time you've been here, has there been much of a change in the role of the AFIP as compared to various university teaching hospitals?

DR. DAVIS: No, it's been remarkably constant. We receive our consultation cases, we dispose of those, and then the bulk of these consultation cases, we use those for teaching purposes and for research purposes. So, consultation, teaching, and research, that really hasn't changed since the idea was first conceived.

Q: Are fewer cases being sent here and more going off to other hospitals as they're picking up this role?

DR. DAVIS: I think our caseload has remained fairly constant. Actually, in our own department, from the time I came here, when we were getting maybe 2,000 or 3,000 cases a year, we got up to 5,000 or 6,000 cases a year. I don't know what it is right now, but I would say, for the past ten years or so, it's been right around that level. There are more people in the country now who are specializing in genitourinary pathology than there were when I came here, and they see a lot of consultations, I know. But I don't think it's impacted significantly on the volume of work we get.

Q: Where are some other centers of genitourinary pathology?

DR. DAVIS: Well, Dr. Faro, at the Mayo Clinic, does a lot of consulting and writing and teaching on the subject. There's a Dr. Murphy in Memphis who's beginning to do more of the

same. Dr. Iyalla, at Indy Anderson in Texas, has done a lot of writing in GU pathology. Those are the main ones.

Q: Speaking of writing, is there much push on the part of the AFIP? Have you seen a change? How was it and is it now as far as asking the various pathologists to publish?

DR. DAVIS: It has been my impression that the publications are doing quite well now. In our department, Dr. Mostofi does most of the writing, but he's turning it out as much or more than ever before. And I think that's generally true. There have been times, over the years, when the director has tried to spur people on to more writing, but I think it's in good shape.

Q: Going back to Vietnam, did you get involved, in your particular field, in any of the controversy over Agent Orange? This was this defoliant that was used there.

DR. DAVIS: No, surprisingly, I didn't. Somehow I escaped that. No, I really didn't hear much about that while I was over there. Of course, things were relatively quiet that year; it was after Tet, and it was before the big flare-up at the end. But, no, I didn't hear much about Agent Orange personally.

Q: In more recent years, have alleged Agent Orange cases come before you?

DR. DAVIS: Well, I know something recently came out in the newspapers about Agent Orange. But over the years since I've been at the AFIP, my knowledge of the subject consisted of talking with Dr. Irey in the hallway periodically. And I was getting the impression that the only thing, if anything, Agent Orange ever caused was innocuous things like epidermal cysts or wens, and probably not those.

Q: Did you have any feel for the AFIP and its role within the armed forces? You're an Army colonel, is that correct?

DR. DAVIS: I was, until last month.

Q: Well, a former Army colonel, by just a month. Within the Institute, did you feel the Navy sort of going its own way, or not? Was this pretty much a well-integrated organization?

DR. DAVIS: It's not really a military environment here. You don't think of yourself as being in the Army or the Navy, until you go outside and somebody salutes. I guess about half of our professional staff are civilians, probably more. It's just not a military environment, and I've never had the slightest hint that there was any inter-service rivalry or anything like that.

Q: That's one of the strengths, I suppose, of this. The museum is part of the AFIP mandate, and it's out here at Walter Reed. Do you get at all involved in the museum, with displays or anything like that? Has that played much of a role in your work?

DR. DAVIS: No. Over the years, I have sent an occasional specimen down to be displayed, but I had the impression that they either didn't have the personnel to handle it or... it didn't seem to ever get on the shelves. Having been a Civil War buff for lo these many years, the museum always held, for me, a fascination. Through most of the '70s, I would eat lunch and go down here and stroll through the museum. That's when they used to keep that door unlocked. Before they had to worry about security, you could just walk from this building into the museum, look around, and go back to the office. So I spent a lot of time in the museum, looking around, but, professionally, I really haven't had much to do with it.

Q: It does seem to have diminished in importance by geography. The museum is away from where everybody goes to see museums in Washington, which is on the Mall. It's just, I think, unfortunate. There should be a medical component to the exhibits there.

What would say makes for a good pathologist?

DR. DAVIS: What I'm going to say probably doesn't apply just to pathologists. But what I stress to young pathologists is, when you're trying to arrive at a diagnosis, to make a clear distinction in your own mind between what you know, what you know you know, and what you know you don't know, and to recognize when you have an element of doubt. The tendency of the younger people is to add up the evidence for this diagnosis, and add up the evidence for that diagnosis, and see which one has the most points, and make that diagnosis, instead of simply stating on the paper the degree of doubt one has. This is true, for example, in some of these prostate biopsies where you have an extremely minute piece of tissue, and you're trying to make a profound diagnosis of cancer on one or two cells. You have to keep a clear idea in your head that you know what it is, or you know that you don't know what it is. And that way, I think you'll make a good pathologist.

Q: Is there a problem when something is sent to you and you say you don't know what it is? Isn't the AFIP sort of the institute of last resort, so they really want you to say that you know what it is?

DR. DAVIS: Yeah, this causes some excitement once in a while, especially on the telephone. We have certain expressions we use when we're not sure.

Q: What are they?

DR. DAVIS: Well, "atypical." I told another pathologist, "We're not sure whether it's cancer or not. Some atypical cells are present on the microscopic slide."

He called back the next day and said, "I told my surgeon what you called this; you called them atypical cells. And he said, `That's nonsense! It's either benign or malignant. Now which is it?'"

And I said, "You tell your surgeon that he's absolutely right: it's either benign or it's malignant. And sometimes we don't know which one it is."

Yeah, there are a lot of those.

Q: Do you find the newer pathologists coming in with a different attitude, or is it just the usual, the young versus the more experienced?

DR. DAVIS: Oh, I don't know. All the young people I see really seem like pretty much what Charlie Davis was when he was young.

Q: Looking back on your time, although you're continuing here, but still, as an active-duty officer, what sort of gave you the greatest satisfaction, would you say, in your career?

DR. DAVIS: The greatest satisfaction. Well, gee. I think you've taken me by surprise here. I really don't know; I haven't given it any thought.

Q: Anyway, I can't think of anything else to ask at this point. I think maybe we can wrap it up.

DR. DAVIS: Wrap it up.

Q: Okay? Thank you very much.

DR. DAVIS: Thank you.